VOICE OF THE DIABETIC

A SUPPORT AND INFORMATION NETWORK

The Diabetics Division of The National Federation of the Blind

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A low blood sugar reaction and what to do about it

by Ed Bryant

Ed Bryant, Editor, *Voice of the Diabetic,* explains methods of handling low blood sugar reactions. "Plan, prepare, and be rewarded!"

A low blood sugar reaction (i.e. insulin reaction or hypoglycemia) can affect both insulin dependent and non-insulin dependent diabetics. Sugar serves as energy for our bodies, and as diabetics we must make certain that our blood sugar does not drop low enough to trigger a reaction. For good health, we must control the level of sugar in our blood at all times through careful diet, exercise, and the use of insulin injections or oral medication.

Many diabetics occasionally experience low blood sugar, which can result in a mood or behavior change, poor coordination, confusion, difficulty in speaking, and/or disorientation. Other symptoms, which may appear suddenly, include sweating, shakiness, a short attention span, dizziness, headaches, and pale skin color. Although this change may be sudden, many diabetics can predict by the way they feel that their blood sugar is dropping too low.

If we, as diabetics, feel a low blood sugar reaction coming on, we should immediately get energy into our bodies. If a reaction is just starting, drink a glass of orange juice or milk, and/or eat a sandwich such as peanut butter. Never use diet drinks or give insulin when the blood sugar is low. If the reaction has progressed to the point that other signs are developing, such as disorientation and sweating, consume some form of concentrated sugar as soon as possible.

A regular-size candy bar can be used. It should contain a high level of concentrated sugar but not a lot of nuts and/or chocolate because they have a high fat content and metabolize slowly in the body. If the diabetic is in a hypoglycemic state, only very sweet candy bars will cause the blood sugar level to rise rapidly enough to be helpful.

Honey is a concentrated sugar that acts rapidly, but it is extremely sticky and can be messy if the diabetic is shaky and disoriented.

There are many kinds of concentrated sugars available over the counter in pharmacies. I like glucose tablets because they act rapidly, dissolve quickly in the mouth, and the container is easy to open. Each tablet is wrapped in a light tinfoil that protects it from perspiration. An adult should take three glucose tablets to combat a low blood sugar reaction. Many health professionals recommend that 20 minutes after taking three glucose tablets, if the diabetic is cognizant of what is happening, he/she should then eat carbohydrates such as milk, a peanut butter sandwich, and/or fruit; but if he is too unsteady, another three glucose tablets should be administered.

For many diabetics, the ideal solution to reactions is pure table sugar. It raises the blood sugar level rapidly and is far more economical than over-the-counter sugars. I am often asked by diabetics how much should be taken for a reaction. As a general rule, if the (adult) diabetic is able to swallow without choking, he/she should take, or be given, two heaping tablespoons (25 grams) of table sugar. After administering, some diabetics will come out of the reaction rapidly while others may take up to 30 minutes. Physicians often recommend that if after about 30 minutes, the diabetic is not totally aware of what is happening, then he/she should be given another two heaping tablespoons (25 grams) of table sugar. While sugar causes the blood glucose level to rise rapidly, it also falls rapidly, because sugar is not solid food, so as soon as the diabetic is able, he/she needs to eat substantial

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Voice of the Diabetic is a national publication of the Diabetics Division of the National Federation of the Blind. It is read by those interested in all aspects of blindness and diabetes. We show diabetics that they have options regardless of the ramifications they may have had. We have a positive philosophy and know that positive attitudes are contagious!

News items, change of address notice and other magazine correspondence should be sent to:

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Social Security, SSI, and Medicare facts for 1990

Marc Maurer, President, National Federation of the Blind, leads the largest group of organized blind citizens in existence. The Federation has more than 50,000 members.

(*Note:* This article appeared in the ***Braille Monitor***, January 1990, published by the National Federation of the Blind (NFB). For information about any aspect of blindness, contact the NFB, 1800 Johnson St., Baltimore, MD 21230. Telephone: (301) 659-9314).

The beginning of each year brings with it certain annual adjustments in Social Security programs. The changes include new tax rates, higher exempt earnings amounts, Social Security and SSI cost-of-living increases, and changes in deductible and co-insurance requirements under Medicare. Here are the new facts for 1990:

FICA (Social Security) Tax Rate: The tax rate for employees and their employers during 1989 was 7.51%. The rate will be 7.65% in 1990. The maximum FICA amount to be paid by an employee during 1990 is $3,855.60, up from $3,604.80 during 1989. The increase results from a higher ceiling on earnings subject to tax, effective January 1, 1990. Self-employed persons will pay a Social Security tax of 15.3% during 1990, and their maximum Social Security contribution will be $7,711.20.

Ceiling on Earnings Subject to Tax: Social Security contributions will be paid during 1990 on the first $50,400.00 of earnings for employees and self-employed persons. This compares to the 1989 ceiling of $48,000.00.

Quarters of Coverage: Eligibility for retirement, survivors, and disability insurance benefits is based in large part on the number of quarters of coverage earned by an individual during periods of work. Anyone may earn up to four quarters of coverage during a single year. During 1989 a Social Security quarter of coverage was credited for earnings of $500.00 in any calendar quarter. Anyone who earned $2,000.00 for the year (regardless of when the earnings occurred during the year) was given four quarters of coverage. In 1990 a Social Security quarter of coverage will be credited for earnings of $520.00 for a calendar quarter, and four quarters can be earned with annual earnings of $2,080.00.

Exempt Earnings: The earnings exemption for blind people receiving Social Security Disability Insurance (SSDI) benefits is the same as the exempt amount for individuals age 65 through 69 who receive Social Security retirement benefits. The monthly exempt amount in 1989 was $740.00 of gross earned income. During 1990 the exempt amount will be $780.00. Technically, this exemption is referred to as an amount of monthly gross earnings which does not show "substantial gainful activity." Earnings of $780.00 or more per month before taxes for a blind SSDI beneficiary in 1990 will show substantial gainful activity after subtracting any unearned (or subsidy) income and applying any deductions for impairment-related work expenses.

Social Security Benefit Amounts for 1990: All Social Security benefits, including retirement, survivors, disability, and dependents benefits are increased by 4.7% beginning January, 1990. The exact dollar increase for any individual will depend upon the amount being paid. Under pressure from senior citizens, Congress has repealed the Medicare Catastrophic Coverage Act. Among other things, that Act required Medicare beneficiaries to pay additional monthly premiums. Beginning January 1, 1990, both the benefits and the premiums resulting from the Catastrophic Coverage Act are gone. Therefore, monthly Social Security checks for Medicare beneficiaries will be increased to reflect lower Medicare premiums. Beneficiaries should expect the decrease in Medicare premiums to be reflected in Social Security checks some time during 1990. A Medicare premium refund check should also be sent to each beneficiary for excess premiums withheld during 1990.

Standard SSI Benefit Increase: Beginning January, 1990, the federal payment amounts for Supplemental Security Income (SSI) individuals and couples are as follows: individuals, $386.00 per month; couples, $579.00 per month. These amounts are increased from: individuals, $368.00 per month; couples, $553.00 per month.

Medicare Deductibles and Co-insurance: Medicare Part A coverage provides hospital insurance to most Social Security beneficiaries. The co-insurance payment is the charge that the hospital makes to a Medicare beneficiary for any hospital stay. Medicare then pays the hospital charges above the beneficiary's co-insurance amount. The basic co-insurance amount for Medicare Part A was $560.00 for a hospital stay in 1989. There was no co-insurance amount for beneficiaries to pay for hospital stays longer than sixty days. This was one of the benefits of the Medicare Catastrophic Coverage Act, which became effective January 1, 1989. That Act has now been repealed, effective January 1, 1990. As a result, the Part A co-insurance amount for hospital stays from sixty-one through ninety days is $148.00 a day. Each Medicare beneficiary has sixty "reserve days" for hospital stays longer than ninety days. The co-insurance amount to be paid during each reserve day is $296.00.

The Medicare Part B (medical insurance) deductible remains at an annual $75.00. The Medicare Part B basic monthly premium rate will be reduced from $31.90 charged to each beneficiary during 1989, to $28.60 per month during 1990. This reduction results from the repeal of the Medicare Catastrophic Coverage Act. The Part B premium is automatically deducted from Social Security checks. The monthly deduction for the first several months of 1990 will be $33.90. All beneficiaries can expect to receive a refund some time during 1990 for excess Medicare premiums paid. For anyone who pays the basic Medicare Part B premium, the refund should be the difference between $33.90 and $28.60, times the number of months of higher premium payments.

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Abandoned!—now what?

by Royanne R. Hollins

Royanne R. Hollins, a long-term diabetic, tells about her physician joining a Health Maintenance Organization and her feelings of abandonment.

What do you say when you are told your physician is leaving the practice? No, he's not "retiring" after years of practice. He is joining a Health Maintenance Organization (HMO) practice that limits who can see him.

My physician and I have worked very hard over the past five years to gain control of this disease that is not treating me well—insulin-dependent diabetes. We have worked from the basics up. We took my care very seriously and have finally achieved pretty good control over the disease. However, even with all of our hard work I struggle with the complications of this disease daily. When I awaken each day, I do not know if I have any eyesight left. It takes time to chase away "Mr. Sandman's" mischievous markings. Once acclimated to my surroundings, I slowly look around to see whatever I can see that day. Whatever vision I have in the morning is usually what stays with me throughout the day. It rarely gets better and periodically gets worse, depending on my activities.

My physician and I have worked very hard over the past five years to gain control. It is a terrible feeling to be out of control. It is a terrible feeling to have something such as diabetes controlling you. We were successful in re-establishing control over my life. Now I live *with* diabetes, not *for* it.

From the beginning, I was a puzzling patient. I had had insulin-dependent diabetes for over 21 years, at the time of my first appointment with this physician. My A1c was very high, indicating poor control. My urine tests were always running in the 4+ range, and I was not yet testing my blood sugars on a meter at home.

My physician introduced me to the home blood glucose monitor. My first

Evolution of a 'night alphabet'

by Virginia Maier

(Editor's Note: This is part of an article that appeared on December 6, 1989 in the *Missourian*, Columbia, MO. In the accompanying chart, braille cells are shown which contain six dots. Large dots indicate where holes would be punched into the paper to form braille characters. For information on any aspect of blindness, please feel free to contact the National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230; phone: (301) 659-9314.)

Defined in absolute terms, blindness is "the absence of vision." However, this definition excludes those who are functionally blind, those who have limited visual stimulation but little or no useful vision.

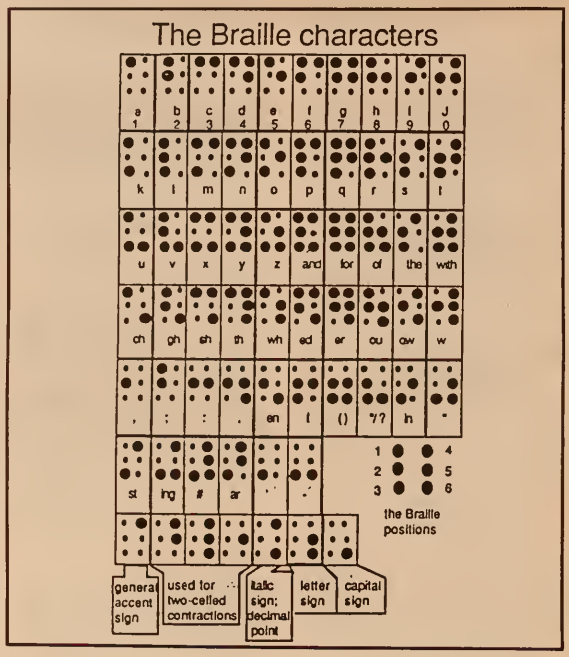
Therefore, a broader definition of blindness has been written by the National Center for Health Statistics. According to the center, to be blind is to be "unable to read ordinary newspaper print, even with glasses."

Legal blindness usually is defined as "visually acuity of less than 6/60 or 20/200 using Snellen's test types or visual field restriction to 20 degrees or less," according to Stedman's Medical Dictionary.

Louis Braille, who lost his sight at the age of 3, first developed the Braille system in 1824 when he was 15 years old. He became interested in developing a writing system for the blind at the National Institute for Blind Children in Paris, where he was a student and later an instructor, when he attended an exhibition of a writing system developed by Captain Charles Barbier. With Barbier's system, known as night writing, messages were coded in dots and embossed on cardboard. This system was to be used by troops for nighttime battle communication.

Braille adapted Barbier's 12-point system into a 6-point system, a code of 63 characters, each of which is made up of one to six dots arranged in a matrix or cell. To read, the fingers are passed over the characters that are embossed in lines on the paper.

Braille published his first paper on his type system in 1829. According to the New Encyclopedia Britannica, however, a universal Braille code for the English-speaking world would not be adopted until 1932.



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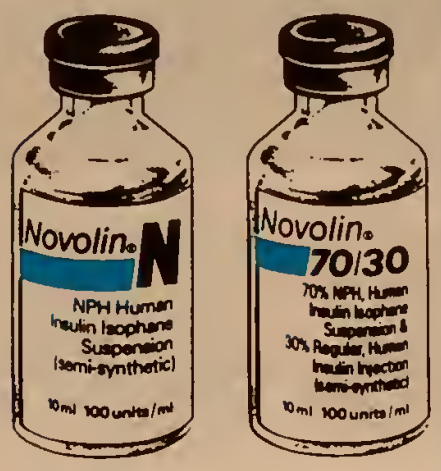

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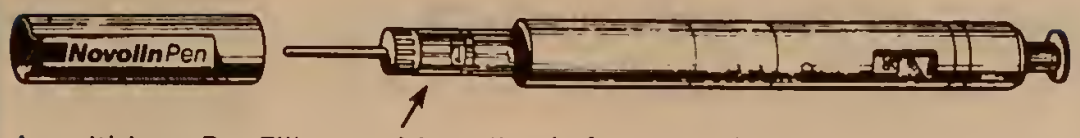

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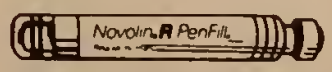

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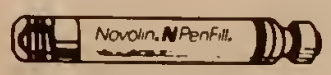

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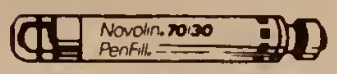

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home testing was enlightening. I could tell my family exactly how my blood sugars coincided with the way I was feeling. When I became irritable and complained of an insulin reaction, I had proof to show them. It was a marvelous, eye-opening experience. I felt I could begin gaining the control I so desperately needed at that point.

With the home testing came learning how to chart my results. My control was so "out-of-whack" that my physician had me charting the test results a minimum of four times a day. He was looking for patterns in what was going wrong with my treatment and control. He used this information to find out if my condition was something we could deal with accordingly, or something that was going to be very puzzling to us.

Going to my doctor's office for checkups (at that point I was going every 6-to-8 weeks) I would be smiling, very proud of my charting handiwork. I was following diligently all of his advice, and I wanted the numbers to tell him so. However, the numbers were not what we wanted to see. I didn't understand the meaning of those numbers. My physician began educating me. It became very important to chart the numbers and then analyze what was happening in my life preceding and following the tests and to note those events in my chart.

If a very low blood sugar popped up we needed to know why: was it taking too much insulin, going overboard in my exercise program, or not eating at the proper time? With that information my physician felt confident he would be able to figure out this riddle of mine.

After eighteen months of charting and adjusting, and charting and adjusting some more we came upon a pretty satisfactory mode of treatment for controlling my diabetes. We progressed gradually from one shot of mixed insulin a day to four shots a day. Slowly, my physician was getting me ready for the next step, an external insulin pump. At that point in time, my early morning blood sugars seemed to be totally out of control. My fasting blood sugars were in the 300 and 400 range, with a previous bedtime blood sugar of 125 to 150. This was terrible. However, we had options.

After more education my physician suggested an external insulin pump at just the right time. This was in lieu of getting up daily at 3:00 a.m. for a fifth injection of insulin. I jumped at the idea. I am not a vain person and I was not concerned about the appearance of "wearing my diabetes on my belt." Once in a while I will shove my pump into a pocket, but about 90% of the time "Pumper" is proudly displayed on my belt.

Once used to the idea of the pump, I was allowed to do my own research, meet with sales representatives of different pump companies and see what each offered. I then "presented my case" to my physician. We put our heads together and chose the best pump for my needs.

It has been over three years since the advent of "Pumper" in my life. I am able to carry on a fast-track lifestyle, and my flexibility is definitely attributable to "Pumper". Now, if my physician had not mentioned an external insulin pump to me, I probably never would have considered one. He seemed to have an uncanny sense of when to push a little harder, and then a little further. Each step took me closer to satisfactory control of my diabetes.

During much of this learning and transition, I suffered from diabetic proliferative retinopathy. I began laser treatments on a regular schedule over fourteen months. After numerous laser treatments, I needed a vitrectomy of my left eye. Of course, my physician worked hand in hand with my retinal specialist. My physician (an endocrinologist) took care of my diabetes (what I consider "me") and my retinal specialist took care of my eyes. During my first hospital stay (after going on my pump) for my vitrectomy, my physician was there for me. I cannot tell you what it means to have someone who not only cares but also knows about taking care of you. My life has been literally in his hands for the past five years. I didn't worry about my diabetes, I knew he would be there for me.

Maybe he made himself too available. Maybe he made himself too vulnerable to my problems (and those of others). Maybe we took advantage of his time, or we did not thank him enough. I cannot even begin to thank him enough. But, why is he leaving?

After a hospital stay for the vitrectomy and numerous laser treatments on the other eye, my eyesight keeps dwindling. Am I going to be totally blind some day? In all likelihood, yes. What happened to my physician when I would come into his office for a checkup, only to have a new hemorrhage taking place the same day? How did my physician feel? He seemed to *really* care. That was the feeling that he shared with me. I felt good, even coping with these life-changing matters. I felt that with his support and understanding I could face it.

I had shoulder surgery in early 1989, and my physician was there when I was admitted to the hospital again. His was the first face I saw upon coming out of the anesthesia. I may not have been a coherent conversationalist, but who could blame me? I knew he was there, and I needed that care from him. So, why is he leaving?

One recent evening, I was at a dinner for the Board of our American Diabetes Association's local chapter. I was stunned to learn the news that my doctor was leaving his practice —not retiring, but *leaving* to join a local HMO. I was shocked! I was told it was only a rumor, but my mind went spinning, literally out of control. I felt as if someone had punched me in the gut and all the air had been forced out of my lungs. I could not breathe! My head was pounding.

(Continued on page 6)

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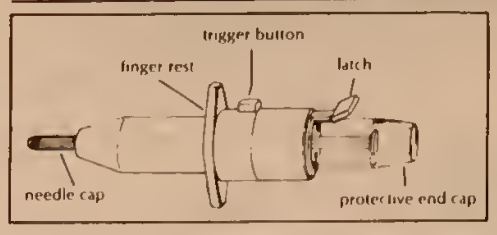

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Abandoned!—now what?

(Continued from page 5)

How could I carry on halfway intelligent conversations the rest of the evening?

Due to poor vision, I could not drive after dark. That was my way out of the Board meeting. When the meeting was about to begin I had to excuse myself to "get home before dark." I had never felt as trapped as I did at that meeting. It was a relief to get outside. However, once outside, my heart began to race.

At home, I repeated all of the rumors I had been hearing to my husband. He tried to calm me down and convince me that they were just rumors. Nice try, but it did not work. After a night of little or no sleep, the next morning my blood sugar was climbing the walls. I knew exactly what was happening. You have heard of what "stress" can do to your system; well I now know it is true, from personal experience. This was, without a doubt, negative stress.

I called my physician the next day to report these terribly high blood sugars and discuss the HMO. Of course, he had no idea that I had heard rumors through another physician we both know. Once we discussed my blood sugar readings, I told him I knew exactly what was causing such an out-of-control response. He asked what it could be. I told him I had heard rumors and from whom I had heard them. So here it was, the confrontation regarding his decision to leave.

Of course, he tried to convince me that the reasons were all very logical. I understood completely with the right side of my brain. However, the left side of my brain kep screaming to cry and to tell him exactly how I felt. But, he mentioned it first: *abandoned.* "I know you will feel abandoned," he said. He thought that was a harsh word, but I thought it quite appropriate. He also mentioned that feelings of "frustration, loss, anger, concern" would be very normal to have in this situation. I still couldn't believe it. Why is he leaving?

My concern became that we, his patients, had relied on him too much, called upon him too often, took too much of this time, and did not thank him enough or return the care he so graciously gave us. I began to feel personally guilty for his decision.

However, he informed me he was having serious second thoughts because of his patients. He said he still cares. He gave referrals to other endocrinologists in town and assured me he was not leaving the practice until September of that year. As far as I was concerned, that was tomorrow.

Before talking to him about his move, I had considered trying to treat myself without any caring physician. I felt I'd been hurt and I didn't want to go through that again. That was a very self-destructive attitude. I am having complications and I do need someone who can sort these problems out logically. In fact, one week before his departure from private practice, I was declared legally blind. However, I didn't want to be part of someone's business. I wanted to remain a person, and be cared about. I wanted to continue a five year relationship. Abandoned? You bet. I sure feel abandoned!

Who can I trust? Who else will know me this well? Who will keep me and Pumper together? There are many physicians in town who are, for whatever reason, anti-pump. I think they would rather their patients stay off the pump so they don't have to deal with it. I understand my physician's thinking behind the reasons for leaving his practice. I also know that there are other competent physicians in my area. I guess my feelings of abandonment and insecurity about the future are part of my self-protective response.

When I began my story I was hoping to have a happy ending. The ending had not yet happened. My physician was still pondering other offers which would allow him to continue giving his patients the care they have grown to cherish and need. Every time I spoke with him he told me not to give up hope. Truly, I wanted to tell you he chose private practice, but that is not the case. Why is he leaving?

He's leaving for business, personal and professional reasons, he tells me. I found myself without a physician I could trust. It will take years to find another one, if I ever can. My physician was one-of-a-kind. I referred friends to him. They changed physicians of long-standing to join him. Now they too must find someone new.

Why is he leaving? Cost. The time for practicing medicine, spending time with your patients, getting to know and care for them, is gone. Now insurance companies are dictating what the physician can and cannot do for the patients. They do not take individual medical histories and personalities into consideration. Patients are numbers on claim forms to the insurance companies and both doctors and patients are suffering. He left for business, personal and professional reasons. Now what?

For the majority of his patients, this story did not have a happy ending. They will eventually find a new physician and some day have the confidence and trust they had with him. However, it will be a tedious process. They will be more protective of themselves and may not be willing to open up quite so fast or thoroughly to their new physicians.

Some patients will follow this physician wherever he goes. If it means joining the same HMO system, they will. Some will try to see him independently of the HMO. It is a tough position for both sides — the patient's point of view is self-serving, as is the physician's. The patient could use the excuse that his or her life is being dealt a blow which is more important than the physician's family and livelihood. That is not at all fair to the physician.

Whenever there is a pending change, there is resistance. I believe there is always a reason for change and things will work out eventually. It is our nature to prefer easy going, status quo — don't give us challenges or make us think too hard. However, when change occurs, let's look to the opportunities that we have.

Abandoned! Yes...and no. None of us can see the "big picture" and someday all of the pieces will fall into place. Until that day and even as that process begins, the patients *will* feel abandoned, fearful, lost and angry. That is normal.

Now what? I think we take this change and turn it into an opportunity. It is up to the individual patient to do what he or she feels is best for him or her at this point in time. Hopefully, those decisions will be well though out, not emotionally based, and beneficial to the patient.

Abandoned! Now what? There are many options. Look to the opportunities knocking at your doorstep. What did I do? I fortunately had the opportunity to join the HMO system spoken of above and follow him. I am one of the lucky ones.

A low blood sugar reaction

(Continued from page 1)

foods such as milk, a peanut butter sandwich, or fruit.

If the diabetic is beginning a reaction and is unable to take some form of concentrated sugar by him/herself, then someone else can mix two heaping tablespoons of table sugar with water and assist the diabetic in drinking the solution. This might work but it can be extremely messy. To simplify this procedure, obtain a 60cc syringe and draw the sugar/water solution into the syringe. It is much easier to insert the syringe into the diabetic's mouth and slowly squirt in the solution. Consumers should be able to obtain 60cc syringes (with no needles) from hospital pharmacies and/or dialysis centers. In the past, I had trouble with low blood sugar reactions and although my wife did a great job of trying to get me to drink sugar mixed with water, much of the solution went on me rather than inside of me. As diabetics, we should be prepared for low blood sugar reactions at all times. I always keep loose table sugar at the office as well as at home and I also have sugar cubes on hand. If I am shaky, it is sometimes easier to pop sugar cubes into my mouth than to take loose sugar. Sugar cubes dissolve and work rapidly.

A convenient method of carrying table sugar is in film cartridges. They will hold two heaping tablespoons (25 grams) and the tops fit snugly so that the sugar will not spill. Many photography shops have empty film cartridges and are often happy to dispose of them. These cartridges can be conveniently carried in purses, briefcases, and suit coat pockets. While diabetics could carry the table sugar packets that are found in restaurants, these packets are flimsy, tear easily, and, if carried in blue jean pockets, they absorb perspiration rapidly, causing a gooey mess. Finally, diabetics should keep some form of concentrated sugar (e.g. sugar in film cartridges) by their bedsides in case of a low blood sugar reaction.

If the diabetic is unconscious and unable to swallow, someone else can moisten a finger, coat it with table sugar and rub it on the gums of the unconscious diabetic. This method will probably have to be repeated several times as not much sugar will be on his/her finger, but what there is will be absorbed rapidly into the body. Glucose tablets, which I talked about earlier, also come in the form of a concentrated liquid. This can be squirted on to the diabetic's gums, which may bring him/her to consciousness so that some form of concentrated sugar can be taken orally.

When the diabetic is unconscious due to a low blood sugar reaction, many physicians recommend that glucagon be given. Glucagon is a prescription drug which must be administered by injection. It acts rapidly and causes the liver to release glucose directly into the bloodstream. After an injection, the diabetic should awaken within 20 minutes. Note: After giving the injection, apprise the diabetic's physician of the situation. Glucose burns off rapidly so it is important that as soon as possible the diabetic consume solid food, especially carbohydrates, which will last much longer than glucose released from the liver. Incidentally, glucagon is expensive. In my area, it costs about $22 per prescription, but I recommend that all diabetics keep glucagon on hand.

For better health and less expense, we diabetics should know how to handle low blood sugar reactions. PLAN, PREPARE, AND BE REWARDED!

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SECURITY EQUALITY OPPORTUNITY NFB

A person with diabetes can and should travel

by Maury Rosenbaum

Individuals with diabetes need not feel that they should avoid travel, but rather, plan to enjoy the world of travel just as non-diabetics do. If your diabetic health is good, you can travel almost anywhere as long as a "plan ahead/be prepared" approach is employed and the same rules as at home are followed.

As in everyday diabetic life, your balance is dependent primarily on 3 factors: insulin, diet (food) and activity, but also on a fourth—mood/stress. The effects of the first three are fairly predictable: Food causes blood glucose to go up while insulin and activity cause blood glucose to go down; however mood changes and stress are less predictable and they can cause blood glucose to go up *or* down. These factors can be balanced so that you achieve diabetic control by employing a concentrated effort and by doing a lot of pre-planning. It is a bit more difficult to do this away from home, but it certainly is *not* impossible.

Enjoyable and safe travel by a diabetic demands that one be prepared both mentally and physically. Travel represents a change in anyone's normal routine and therefore must be recognized as such. Close monitoring and appropriate adjustments are crucial and remain the personal responsibility of each individual. Consultation with your physician or a diabetes professional can be useful and is recommended before you travel, especially if you are a recently-diagnosed diabetic or if you are an infrequent traveler. If you encounter complications related to your diabetic condition, travel should be embarked upon only with your physician's approval. With a common sense approach of pre-planning, most people with diabetes need not curtail their travel plans.

Before traveling, consider the following points:

- Always take more syringes and insulin than you think you need.
- Carry a letter and extra prescriptions from your physician, stating that you have diabetes plus any other related medical information.
- Wear your Medic-Alert bracelet or necklace and carry the convenient card they provide.
- Whenever possible, travel with a spouse or companion who understands your diabetic condition. If you must travel alone, be sure to inform airline personnel, hotel managers, tour guides, etc. that you have diabetes.
- Expect delays (traffic jams, delayed flights, late baggage, etc.) and be prepared by taking along extra food, snacks, juices, etc. PLUS be prepared mentally to reduce the emotional excitement of travel which will affect blood glucose levels.
- If your travel includes a sunnny destination, be extra careful about over-exposure to the sun's rays.
- If your travel includes a non-English speaking country, learn a few words and phrases like:
  — I am a diabetic
  — I need sugar
  — I need juice
  — I need a doctor
- If your activities will be more (or less) strenuous than your normal routine (and they probably will), be aware of them and make the appropriate diet and/or insulin adjustments.
- Take along short-acting regular insulin (even if you do not normally use it) to enable you to make quick adjustments, when and if necessary
- Never pack insulin, syringes or any medication in your luggage — always carry them with you!
- If your skin is sensitive to soaps other than your normal brand, take along your regular brand.
- "Break-in" new shoes well in advance of your trip.
- Keep detailed records regarding insulin, food, activities, etc. to assist in planning your next trip.

Diabetic Traveler's Checklist

- ☐ Syringes, insulin, swabs, blood glucose monitoring equipment; if traveling overseas, take along extra batteries!
- ☐ ID tag and/or card indicating you have diabetes.
- ☐ Medical history & emergency telephone numbers.
- ☐ Extra prescriptions and letter from your physician.
- ☐ First aid kit (contents will vary depending on your needs, but it should include the basics).
- ☐ Carbohydrate snacks, instant glucose, sugar or hard candies.
- ☐ Sun screen or sun block.

So, with proper precautions and medical supervision, individuals with diabetes can stop dreaming and start packing.

(*Note:* This article appeared in the *Diabetic Traveler*, P.O. Box 8223, Stamford, CT 06905; phone: (203) 327-5832. Reprinted with permission.)

Diabetes: Controlled but not Conquered

(**Editor's note:** Following is a press release we received from Squibb-Novo, Inc. Telephone toll-free: 1-800-727-6500.)

An estimated 12 million Americans suffer from diabetes mellitus, a condition caused by a severe deficiency of insulin that can lead to blindness, kidney disease, or heart disease and strokes. The disease dates back to 1500 B.C. when it was identified by the Egyptians. The cause is still unknown, but researchers are investigating such factors as heredity, environment, lifestyle and viruses.

Diabetes develops when the pancreas no longer produces enough of the hormone insulin or when the body cannot use the insulin which is produced. When insulin is present, a sugar called glucose enters the cells where it is burned for energy. Without insulin, glucose builds up in the blood and eventually causes life-threatening complications.

There are two types of diabetes: Type I is called insulin-dependent diabetes (IDDM). People with this type of diabetes must take daily injections of insulin. About 20 percent of diabetics are Type I. Until recently, Type I was called "juvenile onset" diabetes because it occurs most often in people under 20 years of age (the peak incidence is 10 to 12 years). The terminology has changed, however, since Type I can occur at any age, though rarely past 40 years of age. Type I diabetes is not inherited directly, though children can be predisposed to it if they have a parent or sibling who is Insulin-dependent. The chance of a child with an insulin-dependent parent developing Type I diabetes before the age of 20, for example, is about one in 300.

Type II diabetes used to be called non-insulin dependent diabetes (NIDDM) because people with this type of diabetes continue to make and use some of their own insulin. About 80 percent of all diabetics are Type II. Formerly called "maturity onset" diabetes, Type II usually develops in adults, most often in people between 50 and 70 years of age, but can also occur in children and adolescents. Most of these people are overweight, and this condition tends to run in families.

Symptoms of Type I diabetes usually are acute, appear in a short period of time, and include excessive hunger, constant thirst and frequent urination. Diabetics with Type I diabetes also feel tired and weak, lose weight rapidly and often seem irritable.

Symptoms of Type II diabetes are generally milder and take longer to develop than those of Type I. People usually complain of fatigue, weakness and hunger. Blurred vision, itching and a tingling sensation in the legs, feet or fingers are also possible warning signs of Type II diabetes.

Diabetes is diagnosed after a physician reviews the symptoms and performs a series of blood glucose and urine glucose tests.

People with Type II diabetes initially may be able to manage their condition by following a prescribed diet and exercise program and, in some cases, by taking an oral medication. However, most of these patients will require insulin injections once or twice a day.

After the discovery of insulin, diabetes was considered by many to be a "cured" disease. This could not be further from the truth. As people with diabetes began to live longer, it was found that the long-term complications of the disease develop in most patients. These long-term complications include:

- *Kidney failure:* This condition occurs 17 times more often in people with diabetes.
- *Heart disease and strokes:* Diabetes is the underlying cause of 50 percent of all heart attacks and strokes. Diabetics are also five times more likely than the rest of the population to develop gangrene.
- *Blindness:* People with diabetes are 25 times more likely to go blind than the general public.

Although there is not yet a cure for diabetes, there have been significant advances in diabetes care and therapies to help the patient better manage this chronic disease. Most recently, there has been a shift in orientation from strictly therapeutic treatments to meeting the lifestyle needs of diabetics. While this progress in diabetes care has decreased the life-threatening problems of the disease, today's challenge is to ensure quality of life for the diabetes patient while maintaining proper levels of insulin and blood glucose.

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Diabetes shouldn't ground travel plans

by Stephen Williams

With the white wine and the fresh vegetables, the calamari was wonderful: bite-sized pearls of fish swimming in a lemony butter sauce, fresh from the Adriatic, caught only hours before by a Yugoslav fisherman.

About eight hours after dinner in Dubrovnik, Yugoslavia, I was laid out in a doctor's office, dehydrating.

Food poisoning causes great discomfort to people who were perfectly healthy before dinner; to diabetics like myself, it is physically traumatizing. My metabolism was in a state of siege, my blood sugar was soaring, and I was unable to keep down so much as a spoonful of water. And thirsty. . .you want to talk about thirsty, let's talk about that night in Dubrovnik.

Fortunately — despite my lack of fluency in the language, Serbo-Croatian — I was able to communicate with the semi-English-speaking doctor and to explain my chronic condition.

I was admitted to a nearby prewar hospital (pre-War of the Roses, I think), and after a diet of intravenous solutions and Fructal sourcherry fruit juice, I was well enough to travel back to Milan, Italy, and enjoy a veal dinner at my favorite trattoria with no side effects.

Not a handicap

I've been a traveler since I bought my first youth fare ticket in 1970 ($200 round-trip to Amsterdam) and a diabetic for 15 of those years. Except for a quick orange-juice snack to counter an occasional insulin reaction—when blood sugar levels drop too low—I've never had to curtail my touring activities for the sake of my condition.

And, although food poisoning probably took more of a toll on me than it would have on a non-diabetic, it's a risk you run in places like Dubrovnik.

Traveling with a chronic disease shouldn't be any more of a handicap than traveling with small children—it requires a bit more patience, some expertise and attention to detail, but neither kids nor a medical condition should sap any enjoyment from a vacation.

For example, travelers who have high blood pressure need only follow their normal routine once they reach their destination, according to Dr. Michael Horan, who treats hypertension at the National Heart, Lung and Blood Institute in Bethesda, Md.

"If you travel 12 hours, you should just start your regular medication the next 'morning'," he said. "Unless you have unstable angina, a traveler with high blood pressure really doesn't have to guard against anything different."

The insulin curve

For insulin-dependent diabetics, timing is a more crucial factor. Because many insulins have a "curve," the diabetic must compensate for the insulin action by eating at proper times; when a half-dozen hours are added or subtracted to his day, he has got to adjust his medication or eating habits.

"In terms of time zones, we like our patients to call us and give us their itineraries," said Suzanne Ghiloni, a nurse educator at the Joslin Diabetes Center in Boston. "We work out their medication schedule from that information."

One rule of thumb, she said, is to break the day into fractions to adjust doses: For example, if you travel from the East Coast to Europe and lose six hours (one quarter of a day), cut back the next day's medication by one quarter. "But always consult with your own doctor first," she said.

Other suggestions from the Joslin for diabetic travelers:

- Before departing, have a check-up to ensure that your diabetes is under good control. Obtain a doctor's letter stating you are diabetic, just in case you are stopped at a customs station for carrying syringes.
- Carry medical supplies—insulin, syringes, blood-monitoring devices—on your person, not in luggage, in case the bags are lost. And ask your doctor for extra prescriptions in case you need to purchase supplies.
- Ask the airline to provide you with a special diabetic meal. Pack some snack packs with fast-acting carbohydrates (concentrated glucose tablets are available and easily transported). Carry an identification card describing your disease and allergies or wear a Medic Alert charm.
- Don't try to break in a new pair of shoes while sightseeing on vacation: Some diabetics have problems with circulation in their feet and hands, and a well-worn, comfortable pair of shoes will ease hours of walking.

Up in the air

"Speaking of circulation," Ghiloni said, "we recommend walking up and down the aisles on a long plane trip to keep it going."

In emergencies, she said, an ill traveler should contact the American Embassy, where personnel can usually supply the names of reliable doctors or hospitals.

In flight — 35,000 feet above the nearest medical facility — the problem of sickness takes on a different slant. Medication negligence — caused by variations in eating patterns and time zones — can be prevented by using common sense, but more serious problems require special attention.

The U.S. Department of Transportation requires airliners to carry bottled oxygen, a basic first-aid kit and a more sophisticated medical kit that includes a stethoscope, blood-pressure cuff, nitroglycerine and adrenaline. Crew members are trained in CPR as well as first-aid. In some cases, the crew will ask for a "doctor in the house," in others the captain may decide to make an immediate landing at the nearest airport.

(*Note:* This article appeared on Sunday, September 3, 1989, in *News-Press,* Chisholm, MN.)

Ronald James, M.D., long-term insulin-dependent diabetic, directs Midwest Diabetes Treatment and Education Center, Columbia, Mo. Dr. James is also the Medical Director of the Central Missouri Diabetic Children's Camp, Inc.

Ask Dr. James

by Ronald James, M.D.

(Note: If you have any questions for Dr. James, please send them to the editor. The only questions Dr. James will be able to answer are the ones used in his column.)

I give my shots in my legs, and one spot has become hard and it is difficult to make my injection there. What causes this, and is there anything I can do to correct the problem?

This problem may occur in some diabetics when insulin is injected daily in the same place. The skin and tissue beneath the skin becomes thickened and scared with the formation of so called "insulin lumps." Absorption of insulin given in this area may proceed at an unpredictably slower rate, thus affecting diabetes control. You should stop giving injections in this area.

Part of my upper leg where I take injections has become very soft or flabby. There seems to be no muscle tone here and the needle goes in very easy. What causes this and should I be making injections in this spot?

The condition you are describing sounds like what is referred to as hypertrophy or "fat pads." There is an increase in the fat tissue beneath the skin in these areas. This tends to occur when insulin is injected repeatedly into the same place. Since injections into these fat pads are not very painful, one tends to give them there more and more. Fat pads are of no particular importance except for being unsightly. I would recommend not giving any more injections into these areas.

As long as my name is not used - can diabetes affect a man's sexual performance? If so, why? Can anything be done to correct the situation?

Yes. This usually results from one of two problems related to diabetes. Arteriosclerosis, called hardening of the arteries, occurs earlier and more often in diabetics and may impair the blood flow to the male sex organs. This may result in the inability to obtain a normal erection and thus to perform the normal sex act. The most common cause of this problem is diabetic nerve disease called neuropathy. The normal male sex act depends upon nerve control. If the nerves are not working properly due to the diabetes, then he may not be able to function successfully. In some cases where hormone levels are below normal, injections of some form of a male hormone called testosterone may be helpful. However this is usually not the problem. Implantable penile prosthetic devices are available and are often quite successful.

Legislative agenda for the blind of America

James Gashel, Director of Governmental Affairs, National Federation of the Blind, works diligently with Congress to improve the lives of the blind.

(**Editor's Note:** This is a reprint of a letter delivered to all members of the U.S. Congress regarding 1990 legislation. For further information contact: James Gashel, Director of Governmental Affairs, National Federation of the Blind, 1800 Johnson St., Baltimore, MD 21230; telephone: (301) 659-9314.)

From: Members of the National Federation of the Blind

To: Members of the 101st Congress

Re: The Blind: Legislative Priorities for the Second Session of the 101st Congress.

Blindness has a dramatic impact on the lives of millions of U.S. citizens. One-half million people in this country are blind, and fifty thousand Americans become blind each year. The lives of millions of others—friends, neighbors, family members, business associates, and co-workers (although not blind themselves)—are nonetheless affected by blindness and its social and economic consequences. As a result, public policies and laws concerning the blind have a profound impact throughout our society.

The blind themselves are best able to understand and explain the personal and social impact of blindness. Loss of eyesight is a unique condition. It is not debilitating in a general sense. Most blind people (and those who know them) do not regard the blind as disabled. Still, misclassification of the blind as disabled has become the greatest social limitation we face.

If a blind person has proper training and opportunity, the physical loss of eyesight itself can be reduced to the level of a mere nuisance. Misconceptions about blindness, coupled with lack of good training and limited opportunities, are the real handicaps. Although most sighted people have had some contact with blindness, it is still largely misunderstood, and it continues to be more a problem of public attitudes than physical disability.

Public policies and laws that result from misconceptions about blindness or lack of information are often more handicapping to the blind than loss of eyesight itself. This is why we have formed the National Federation of the Blind (NFB). We are the blind speaking for ourselves, and NFB is our vehicle of self-expression. We join the NFB through local chapters and statewide organizations which are located everywhere in the United States.

The blind are well organized at the grass-roots level throughout the United States. Our policy positions are developed and determined by vote of the blind themselves. This is why lawmakers and the public at large now recognize the NFB as the "voice of the nation's blind." Our priorities for the second session of the 101st Congress express our assessment of current issues requiring action by Congress on behalf of blind persons of all ages.

(1) ***Congress should enact the Air Travel Rights for Blind Individuals Act.*** This request seeks approval of legislation to make unmistakably clear the Congressional intent that persons who are blind may not be subjected to unfair and discriminatory restrictive seating practices of airlines. The "Air Carrier Access Act" (Pub. L. 99-435) already prohibits discrimination against "the handicapped" in air travel, but the Federal Aviation Administration and the Department of Transportation (DOT) are preparing to issue restrictive seating rules requested by the airlines. The rules are expected to give commercial flight crewmembers a choice in classifying passengers into those who may have direct access to emergency exits and those who may only have secondary access. Blind persons would by regulation always have secondary access to the exits.

The airlines and federal authorities appear to have little regard for the law or the will of Congress. It is outrageous that blind people are still subjected to arrests when they take seats assigned to them by the airlines. Law-abiding blind citizens have been hauled off to jail for not accepting discriminatory orders of airline personnel. Yet, DOT enforcement authorities refuse to intervene to protect the personal liberties and safety of blind passengers. The fact sheet entitled "Air Travel Rights for the Blind" gives more details and suggests specific legislation that the 101st Congress should enact. There would be no cost to anyone, including the government and the airlines.

(2) ***Congress should approve the "Right to Participate Without Modification" amendment during further consideration of the Americans with Disabilities Act.*** This request seeks to prevent future use of the Americans with Disabilities Act as a source of legalized discrimination against the blind. Our common experience is that laws which prohibit discrimination against the disabled as a general class tend to have distorted and unintended effects which may be detrimental in specific disability cases. The "Right to Participate Without Modification" amendment would establish clear-cut requirements that must be met in order for modified services or benefits to be provided in a nondiscriminatory manner.

It is harmful to us when accommodations are made that falsely imply limitations caused by blindness. From the moment it is signed into law, the Americans with Disabilities Act will affect blind persons and millions of others in almost every activity of our lives. Even the small gains made in passing equal rights laws for the blind and disabled in many states will be threatened or could be lost forever. The right of access for some should not also become the right to cause discrimination against others—those of us who already have access. The fact sheet entitled "Preventing Legalized Discrimination

Against the Blind: Changes Needed in the Americans with Disabilities Act" gives more details on the "Right to Participate Without Modification" amendment. If The Americans with Disabilities Act becomes law, it must not be approved without this amendment.

(3) ***Congress should amend the Social Security Act to give blind persons the flexibility they need in choosing acceptable and desirable sources of post-secondary training and employment services.*** This request seeks enactment of legislation to allow blind persons to select, design, and pursue the assistance required to become employed and self-supporting. Under existing law, beneficiaries of Social Security programs (and all other blind people seeking training and employment services) are blocked in most cases from obtaining this help through any agency other than the one agency designated to provide rehabilitation services to the blind in each state.

Existing law authorizes Social Security to reimburse the state agencies when a beneficiary achieves employment, but states are reluctant to participate substantially in this "results-oriented" program. Funding participants (rather than programs) would be a better option. That can be done by letting each beneficiary choose the agency or training source that will be most responsive. The beneficiary (not a government agency) is often in the best position to know which training sources can best meet the need. Under a plan which gives blind beneficiaries greater freedom to choose among providers for their training and employment programs, cost-effective reimbursement for services could be made to private agencies and training sources as well as to state rehabilitation agencies. The fact sheet entitled "Breaking the Monopoly: Expanding Choices in Rehabilitation for Blind Adults" gives more details and an outline of the specific legislative changes that the 101st Congress should enact.

Blind people are asking for your help in securing positive action by Congress in the areas outlined here. Legislative proposals are now pending to achieve each of our objectives. Many priorities confront this session of Congress, but the needs of the nation's blind must not be neglected in the legislative agenda this year.

We of the National Federation of the Blind stand ready to assist our Representatives and Senators to understand our needs and to take meaningful action to address them. In partnership with the National Federation of the Blind, each member of Congress can help build better lives for the blind both today and in the years ahead.

• • •

Fact Sheet
AIR TRAVEL RIGHTS FOR THE BLIND
S. 341 (S. Rept. 101-45), H.R. 563

Short title: A bill to amend the Federal Aviation Act of 1958 to prohibit discrimination against blind individuals in air travel.

Senators to cosponsor: contact Senator Hollings.
Staff contact: Steve Palmer, Majority Staff, Committee on Commerce, Science, and Transportation, (phone) 4-9350.
House members to cosponsor: contact Congressman Traficant.
Staff contact: Dan Blair, (phone) 5-5261.

The Problem: Arbitrary restrictions on seating of blind passengers are a most common form of degrading discrimination against the blind in air travel. Airline personnel routinely humiliate and bully blind people for sitting in their assigned seats near emergency exits. Law-abiding blind passengers are even arrested and hauled off to jail for taking seats assigned to them by the airlines.

Lengthy flight delays are common in these incidents. Airline personnel create the delays and use them as a tactic to humiliate blind passengers publicly. As a result other passengers are encouraged to side with the airlines and are incited to express anger against the blind. In these situations blind persons are trapped and subjected to discriminatory treatment which cannot be resolved merely by moving from seats near exits.

Existing Law and Regulations: Section 404(c) of the Federal Aviation Act of 1958 (enacted by Pub. L. 99-435) prohibits discrimination against qualified handicapped individuals in air travel. Citing this law as a reason, the Federal Aviation Administration (FAA) is preparing to issue a rule requiring secondary access to exits for all blind passengers on all flights. Other passengers chosen by airline personnel would have primary access to exits. In a related rulemaking, the Department of Transportation (DOT) has also proposed a rule to give the FAA a free hand in imposing seating restrictions, regardless of their discriminatory impact.

The combined effect of the FAA and DOT rules would be to nullify the nondiscrimination mandate of Pub. L. 99-435. The regulatory scheme of using two rules to reach a single discriminatory result was devised by the airlines and the government to circumvent the clear intent of the law. Officials have said that the rules will "not discriminate against the blind," but "sight will be required" for any passenger to be seated near an exit. The FAA has never had a regulation to limit seat assignments of the blind. Citing evidence gathered in 1973, the FAA concluded in 1977 that a seating restriction rule was "not in the public interest." There is no factual basis for a contrary position today. However, the final, discriminatory rules are expected to be issued shortly.

Proposed Legislation: Congress should enact the Air Travel Rights for Blind Individuals Act. Identical Senate and House bills are pending with sizable bipartisan groups of cosponsors in each chamber. The Senate bill has been favorably reported from committee and is ready for floor action. Hearings have not been held in the House.

The bill calls for adding the following sentence to section 404 (c) of the Federal Aviation Act of 1958: "An air carrier shall not restrict seating in aircraft on the basis of the visual acuity of a passenger or the use by a passenger of a white cane, dog guide, or other such means of assistance."

This measure would maintain the FAA's responsibility to regulate safe air travel. Criteria that have a safety-based justification could be used to support policies that exclude passengers from seats near emergency exits. Restrictions based on blindness or visual impairment have no safety basis and would therefore be prohibited.

Need for Legislation: According to the Senate Commerce Committee's report: "In passing the Air Carrier Access Act, Congress clearly intended that blind persons not be subjected to discrimination in any form in their use of air transportation. Restrictions, imposed in the name of safety, but lacking any legitimate safety basis, that exceed those imposed on other passengers are one such form of discrimination...The mere presence or absence of a handicapping condition, as in the case of blindness, should not in and of itself suggest the need for seating restrictions. Congress did not intend for the FAA to impose discriminatory seating restrictions on blind individuals, especially when such restrictions had been found earlier by the FAA to be unnecessary." (See S. Rept. 101-45.)

Approval of this legislation is necessary now to pre-empt the expected regulations. Safety is a matter of serious concern to proponents of this bill. Arbitrary assumptions about passengers' abilities—excluding all blind persons from all seats with direct access to exits—will compromise safety for the blind and others on all flights. Backers of this seating ban at the FAA and the airlines are simply emotionally committed to beating down the blind in hopes of being praised for promoting safety. At the same time they are permitting airports and airways to become so crowded as to create a very real public danger. Reports have shown that the FAA's maintenance standards have actually contributed to the loss of lives.

Not one life has ever been lost because a blind person was seated near an aircraft emergency exit. Lives have been lost when sighted persons have improperly opened the exits. Still, no one would seriously propose banning all sighted persons from seats near exits. Similarly, the bill now pending is a serious solution to a real problem. The commitment to safety and civil rights for the blind was made in good faith by Congress and President Reagan. It must not now be subverted by administrative action.

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Fact Sheet
PREVENTING LEGALIZED DISCRIMINATION AGAINST THE BLIND: CHANGES NEEDED IN THE AMERICANS WITH DISABILITIES ACT

Background: The Americans with Disabilities Act has passed the Senate as S. 933 and is pending in the House of Representatives as H.R. 2273. This measure is being proposed to prohibit discrimination against persons with disabilities. Under the bill it would be discriminatory to deny disabled persons access to (1) employment; (2) services, programs and benefits of state and local governments (including public transportation); (3) public accommodations and transportation provided by private entities; and (4) telecommunications services.

The bill identifies physical barriers to the disabled as discriminatory. Its premise is that limits on physical access lead to restricted participation or outright denial of opportunity. Under the bill, opportunities are to be barrier free. A legal standard of "accommodated participation" is used as the rule of thumb for nondiscrimination. This standard differs from the "equal participation" standard adopted by the Civil Rights Act of 1964. Physical accessibility requires modifications to architectural design features. Changes in programs in order to accommodate them to the physical limitations of the disabled are also required by the bill.

The Problem: The accommodated participation standard is appropriate in some instances but not appropriate in most. The focus on accommodations in the case of the blind reinforces the false presumption that blind people are denied access unless special modifications can be made for them. This misconception about the blind is harmful and leads to discrimination. While blind people are vitally concerned that federal laws must be passed and enforced to prohibit discrimination, Congress must act carefully in setting the civil rights standard. Otherwise, the law intended to prohibit discrimination could actually promote new forms of prejudicial treatment. This will happen if blind people are required to use legally mandated accommodations that they do not want or need.

A 1986 law requiring airlines to make services accessible to disabled persons is proof that blind persons can face serious harm from a general nondiscrimination law aimed at removing physical barriers. Seating restrictions, never before required to be imposed upon the blind under federal law, are now being planned by the Federal Aviation Administration. The law did not contemplate such a

(Continued on page 12)

Legislative agenda

(Continued from page 11)

result to occur in the name of nondiscrimination. In like manner the Americans with Disabilities Act could have the same damaging impact on civil rights in other areas by restricting the blind to use of accessible hotel rooms and through seating restrictions for the blind on public buses. Policies such as these are predictable unless clearly prohibited by the plain language of the law.

Proposed Amendment: Congressman C. Christopher Cox of California is preparing to offer an amendment to give each person with a disability the right to reject any physical or programmatic accommodations that they do not want or need. The "Right To Participate Without Modification" amendment would establish clear-cut requirements that must be met in order for modified services or benefits to be provided in a nondiscriminatory manner.

The guidelines for nondiscriminatory accommodations would be placed in a revised portion of section 302(b) of the bill and in a new section 514, proposed to be added to title V at the end of the existing text. These sections prohibit policies requiring the use of accommodations for all disabled persons. Forcing blind persons to accept or use unwanted accommodations would be discriminatory. Services or benefits provided to disabled persons could not be different or separate from the services or benefits provided to others unless each disabled person also has the opportunity to receive exactly the same services or benefits that are provided to nondisabled persons.

Need for the Right To Participate Without Modification Amendment: The accommodated participation standard is no doubt very appropriate for many persons with disabilities. This standard should help to make their participation possible. For blind persons, however, the accommodation standard incorrectly assumes a degree of inability and directs unwanted and even harmful changes. The individual's true abilities are overshadowed by accommodated participation, and the changes made become the focus of everyone's attention. It is assumed that the individual could not participate were it not for the accommodation.

It is harmful to us when accommodations are made that falsely imply limitations caused by blindness. Opportunities necessarily depend on public understanding and social acceptance. This will be the case with or without the Americans with Disabilities Act. Blind people want to be accepted on terms of equality with the sighted. This is a proper and realistically achievable objective. Our equality will be blocked, however, if we are faced with a federal law that implies a degree of permanent inequality.

From the moment it is signed into law, the Americans with Disabilities Act will affect blind persons and millions of others in almost every activity of our lives. If the Act sets accommodation as the standard for using most facilities and services, many thousands of us will be forced to endure discriminatory practices in almost everything we do. Even the small gains made by the adoption of equal rights laws for the blind and disabled in many states will be threatened or could be lost forever. The right of access for some should not also be the right to cause discrimination against others—those of us who already have access. There must be a balance. The "Right to Participate Without Modification" amendment will help to strike that balance. The Americans with Disabilities Act must not be approved without it.

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Fact Sheet
BREAKING THE MONOPOLY: EXPANDING CHOICES IN REHABILITATION FOR BLIND ADULTS

H.R. 855: *A Bill:* "To amend titles XVI and II of the Social Security Act to promote the rehabilitation of blind beneficiaries under the SSI and OASDI programs, and to assure that the blind receive the most appropriate employment and training services which are available by permitting them to select the agencies to which they will be referred for such services."

Background: Federal support for rehabilitation of the disabled began in 1920, but programs for the blind did not receive federal assistance until 1943. Current rehabilitation services include various forms of medical, social, recreational, vocational, educational, and research-oriented programs that are intended to improve the living conditions and life styles of all disabled persons in America.

Employment was once the principal goal of the law, but the emphasis has shifted to serving the diverse social and independent living needs of the entire disabled population. The employment goal is now subordinate. However, recreation, social services, and even medical care needs will almost all be met for the vast majority of blind people if they get suitable jobs with pay and responsibilities commensurate with their individual abilities.

Existing Law: The Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, authorizes most of the current federally supported rehabilitation programs. Almost 1.5 billion dollars in federal financial assistance is distributed to the states under Title I of the Rehabilitation Act. The designation of a specific state agency to serve the disabled and blind is a prerequisite for receipt by any state of its share of the federal funds.

Titles XVI and II of the Social Security Act also authorize the use of separate funds to pay for the costs of rehabilitation services for disabled and blind people who receive Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits. The beneficiary rehabilitation funds provided by the Social Security Administration are in addition to direct appropriations for rehabilitation services approved annually by Congress. For largely historical reasons the Social Security Act only allows beneficiaries to obtain rehabilitation services from the state agency designated for them under the Rehabilitation Act.

Under these arrangements options for most blind people to choose among training sources are realistically nonexistent. This lack of a free choice is a major deterrent to effective, responsive training and employment services and leaves almost 80 percent of employable blind people largely outside of our nation's workforce.

Proposed Legislation: Congress should amend the Social Security Act to give blind SSI and SSDI beneficiaries greater freedom to develop individualized training and employment programs. A bill to accomplish this objective has been introduced in the House by Congressman Harold Ford. It presents a natural alternative to the present Social Security funding arrangement by allowing recipients of SSDI or SSI benefits to designate for themselves individually selected agencies, public or private.

The Bush administration has sent Congress a similar legislative proposal, included as title V of the Administration's proposed Social Security Amendments of 1989. Under the bill, SSI and SSDI beneficiaries would receive rehabilitation services provided by public or private agencies. State rehabilitation agencies would become one of several potential sources of service. Referrals for service would be made directly by the Social Security Administration and not by the state rehabilitation agencies.

Need for Legislation: Expansion of the Rehabilitation Act to support a broader range of services (including those of a social, recreational, and independent living nature) has substantially increased demands upon state rehabilitation agencies to provide a wider variety of services to growing numbers of disabled persons. As a result of this trend state rehabilitation agencies are less able to respond to the training and employment aspirations of blind persons seeking service. The training and employment aspirations of blind persons have also changed dramatically, further stretching the Rehabilitation Act's single state agency system beyond its limits. The needs and potentials of the blind in the 1990's are simply not the same as they were in the 1940's, yet services are supposed to be provided to the blind through essentially the same state-federal administrative structure that has been in place for over fifty years.

Changes in law are needed to respond to these evolving service demands. The legislation seeks authority for the Social Security Administration to contract for rehabilitation services on behalf of its beneficiaries. This is the next logical step in the evolution of rehabilitation services for the blind. The legislation would leave the existing Rehabilitation Act structure and funding arrangements intact and reduce demands on overburdened rehabilitation agencies. Blind beneficiaries would have greater flexibility in choosing among existing or new service providers. State boundaries and limits on out-of-state spending would no longer be roadblocks for blind persons in finding the best program to meet individual needs. Agency accountability would be increased by giving blind persons the flexibility to choose programs that work. In addition, Social Security funds paid to achieve training and employment goals would reduce demands for continuing cash outlays from the SSI and SSDI programs. This is a cost-effective approach that Congress should now enact.

The diabetes corner

by Mildred "Barry" Friedman

Please don't be angry with me. I am not advocating early morning wake-ups to simplify the life of a diabetic. "Pre-dawn" (final paragraph, column 1, pg. 16, last issue of *Renalife)* should read "pre-drawn." Now that you can sleep longer here's an experiment that may interfere with your slumber in another way.

According to some researchers, diabetics fear insulin reactions (low blood sugar) during or just after sexual intercourse. The literature commonly available to diabetics reinforces this concern and advises eating carbohydrates before indulging in sex. (I have never read anything like that or come across any mention of it before but anyhow. . .) Five men and 11 women — all IDDMs (Insulin Dependent Diabetes Mellitus) — agreed to test their blood sugar 15 minutes before and 15 minutes after intercourse. There was a fall in blood glucose in 27 of 34 episodes but no symptoms of hypoglycemia appeared. Draw your own conclusions and consider the meaning for NIDDMs (Non-Insulin Dependent Diabetes Mellitus).

Does sexual activity impose stress? While not mentioned in a paper concerned with the effect of reducing stress on the daily glucose range of previously stabilized IDDMs, it should be kept in mind. In general, the effects of stress on diabetic blood sugar are debatable. Do sugar levels go up? Do they go down? If the stress is perceived as positive, sugar

levels may fall, and if negatively perceived, levels may rise. The nature of the stress, specific emotion activated, degree of anxiety, degrees of diabetic control at onset, extent of autonomic neuropathy, and the combination of stress hormones involved are a few of the contributing factors in reaction to stress. Anxiety is difficult to measure but the patients were given a questionnaire which tried to judge entry levels, mood, worries, changes in diet, changes in exercise, and relaxation practices. Two women and three men (stable, three shot-a-day IDDMs) were given biofeedback training to reduce tension; they were tested before training, during early training, during late training, and after training. Four of five people showed slightly decreased blood glucose levels which, while not mathematically significant, may translate into fewer microvascular complications (retinopathy). What happens with stress when diabetics are under poor control? As with many studies more questions are raised than answered but these researchers claim only to be publishing a preliminary report.

Studies of the effects of insulin pump therapy as opposed to multiple insulin injections can no longer be considered preliminary. One group used pump therapy early (four to six years into the diabetic course), to see if renal-retinal changes could be interfered with. Twelve patients were put on pumps and 12 continued conventional, intensive multiple-injection therapy. Three of 12 pump patients and four of 12 conventional patients showed continued retinal deterioration. Conclusion: early pump use is of no value in stopping retinal changes once they've begun. However, pump use did reduce GFR. GFR (Glomerular Filtration Rate) is a measure of how well the kidney is filtering. In early diabetic renal disease, filtration is above normal or super good (a bad sign of the renal failure that is to come) so perhaps slowing GFR delays kidney loss.

Another measure of kidney function is the amount of the protein albumin being excreted. None should be, but in early diabetic kidney disease, very small amounts are found in the urine. The amount excreted was unchanged with the use of a pump to control blood sugar, but at least proteinuria was not increased. The difference between these two measures of kidney function (GFR and proteinuria) may show control by different mechanisms and that one is reversible, the other is not. Conclusion: early use of a pump may delay kidney disease. Insulin infusion pumps are not universally accepted because the degree of blood sugar control they permit is not strikingly different from that achieved with multiple insulin injections; they are invasive therapy; and their use may lead to increased hypoglycemic episodes.

A belief that pump use (less obvious to observers than taking out a needle and injecting yourself) would aid in controlling diabetes in children, teenagers, and young adults was the reason for putting a group of poorly controlled diabetics in these categories on a variety of pump types. Basically, continuous insulin infusion did no good. They seemed to find many ways not to conform: poor care of pump, forgetting to use it, sloppiness resulting in infections at needle implant site, lack of blood sugar monitoring. Control was improved during hospitalizations but not once they were let loose. Another way to have them accept and manage their disease must be found.

The three major factors in control of diabetes are insulin, exercise, and diet. Questioning both patients and professionals about what was the most difficult element in living with diabetes, researchers received one overwhelming answer: DIET. Patients said they were often not given diet prescriptions and when they were, meal planning was not explained to them in an adequate fashion. People's life styles were being altered; experience tells us that this takes a long time and much understanding to accomplish. Patients said they didn't conform because they didn't understand.

Another set of experimenters worked with 31 doctors from a rural/suburban community. The doctors were given no specific education about diabetic diet, but other areas of diabetic care were covered. After training, these physicians gave more instruction in self-blood glucose monitoring and suggested its use more often. They also examined feet on a more regular basis. Patients, cared for by these doctors, received more patient education literature, and were made more aware of foot care and the complications from lack of it. Those on insulin were more apt to test urine for ketones. There was, however, no change in the approach to diabetic diet. Possibly then, slanting the education of professionals toward a better understanding of the importance and applicability of a good diabetic diet (as well as what that consists of) could modify diabetic care.

The flip side of the coin is to educate patients. Attempting to do so, S.A. Mazzuca, et. al., in Canada, designed seven content modules. Each included lectures, skill exercises, behavioral modification techniques, and follow-up. Assessment 11 to 14 months after training showed only rare differences between the educated and the noneducated patients although self-care skills and compliance were slightly better in the first group. Back to the drawing board.

Weight loss is often considered simultaneously with sticking to a diet. Ten NIDDMs and five non-diabetics lived on a metabolic ward for 36 days consuming only 300 calories per day as high quality liquid protein and vitamin mineral supplements. Good compliance and acceptance were prevalent and a feeling of hunger disappeared after a few days. Glucose control was normalized in diabetics and both groups showed normal lipid levels. Interestingly, non-diabetics who began more obese, lost more weight than diabetics.

Most of us don't live on metabolic wards but we are all concerned with diet. According to reports in the media, high fiber diets seem to make blood sugar control easier to attain. Those of you who have rising creatinine levels be aware that high fiber is reputed to lower serum creatinine.

Obesity is a component in the development of Type II diabetes and is probably, in some way, a physical demonstration of the biochemical differences present in NIDDMs. Type II is thought of as appearing later in life but there is a pool of children called MODY (Maturity Onset Diabetes of the Young) or NIDDMY (NIDDM of the Young). Usually they are ethnically isolated and are either Native Americans or Indians from India (Columbus didn't know how good a prophet he was when he got these two groups confused). Lower C-peptide levels characterize the disease and in some MODYs an impaired response exists to a glucose challenge — but not to challenge with glucagon or tolbutamide (both are glucose lowerers). Explanation of the foregoing: Type I diabetes is a lack of insulin, Type II is a lack of ability to use the insulin which the body produces in sufficient quantity; C-peptide and insulin are tied together in the chemical compound that splits into insulin and C-peptide, so measuring the amount of C-peptide tells how much insulin was released. Maybe NIDDMY is a combination of a touch of Type I with a prevalence of Type II.

(*Note:* This article appeared in *Renalife* published by the American Association of Kidney Patients; telephone: (813) 251-0725. Reprinted with permission).

Diet mainstay of diabetes treatment

Diet is a mainstay of diabetes treatment. A diet can help someone with diabetes:

—Achieve and maintain desirable weight. Many people with diabetes could control the disease by keeping their weight under control.

—Avoid extremes of blood glucose.

—Limit foods that may contribute to heart and blood vessel disease. These conditions are more frequent in people with diabetes than in those without.

Although doctors prescribe diet as a part of diabetes treatment, they cannot always take the time or have the knowledge of diet planning needed to design a personalized diet for someone. A professional who is knowledgeable about both diabetes and diet can design a diet that is healthy, but at the same time appealing and flexible with foods that are tasty as well as healthy. No one has to be limited to a pre-printed, standard diet. Someone with diabetes can get assistance in the following ways:

—A doctor may be able to recommend a local nutritionist or dietitian with knowledge of diabetes.

—The local chapters of the American Diabetes Association, American Heart Association, American Dietetic Association or a local hospital may be able to offer names of qualified dietitians or nutritionists.

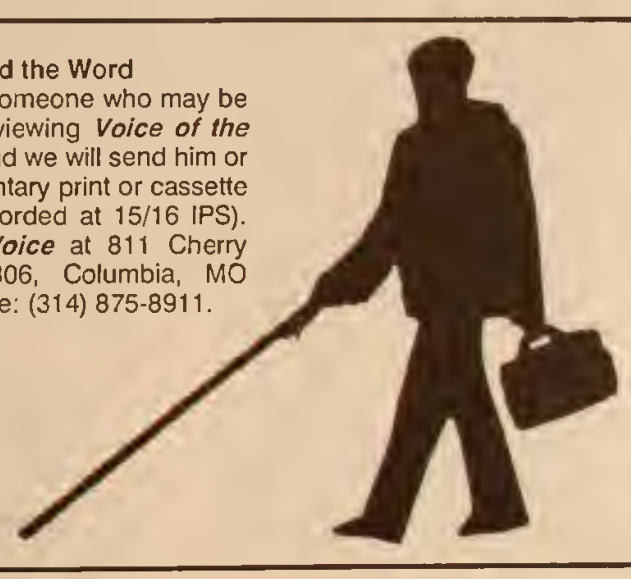
People with diabetes have twice the risk of heart disease as those without diabetes. Diabetes raises the risk that someone will develop heart disease. High blood cholesterol levels raise the risk of heart disease. Losing weight can help lower blood cholesterol as will limiting saturated fats and cholesterol in the diet in favor of unsaturated and monounsaturated fats.

A doctor or nutritionist can advise someone on this aspect of diet.

(*Note:* This article appeared on December 12, 1989 in the *Daily Statesman*, Dexter, MO)

Spread the Word

If you know someone who may be interested in reviewing ***Voice of the Diabetic,*** ask and we will send him or her a complimentary print or cassette copy (tapes recorded at 15/16 IPS). Contact: The ***Voice*** at 811 Cherry Street, Suite 306, Columbia, MO 65201; telephone: (314) 875-8911.



Fighting diabetes in older adults

by Igor Lobanov
Special to Senior News

SAN DIEGO—The history of treating diabetes goes back a long way.

Stone tablets carved in ancient Sanscrit described a group of people who were overweight and suffered both increased thirst and urination. The stone-carved report went on to describe how, when the group was placed on a weight-reduction program, all the symptoms vanished.

Dr. Loren G. Lipson, chief of geriatrics at the University of Southern California School of Medicine, used the historical perspective to emphasize that, for many seniors, diet and exercise are still effective in treating diabetes.

Lipson spoke to a group of mature market journalists at a four-day conference, "Senior Citizens: The Major Issues for 1990."

Nearly 30 percent of people in their 70s and 80s have diabetes, while another 10 to 20 percent have abnormally high blood-sugar levels. These people are at risk for heart disease, Lipson said.

The problem, he explained, is that many older adults find it hard to change longtime eating and exercise habits.

Fully 95 percent of Lipson's patients do not maintain recommended dietary standards, he said. His colleagues who treat patients in more affluent neighborhoods have only a slightly better average—93 percent.

For those who can't stick to diets, Lipson recommends oral agents, meaning non-insulin drugs that lower glucose production. The drugs also can stimulate the pancreas to produce more insulin and can make the body more sensitive to the insulin it produces.

The major symptoms of diabetes include weight loss, excessive thirst and frequent urination. Lipson cautions that because diabetes is normally a progressive disease, and usually doesn't cause pain, patients often forget the disease can be lethal if not treated.

Thus, said Lipson, diabetes patients must be "compulsive" about taking medication properly.

Lipson also recommends that diabetes patients have physical examinations at least every two years.

(*Note:* This article appeared in November 1989 in the *Senior News*, Ft. Meyers, FL)

New view of fatty foods in diabetics' diets

by R. Weiss

Patients with non-insulin-dependent diabetes mellitus (NIDDM) traditionally take dietary advice with a grain of salt. For years, they've heard researchers present conflicting conclusions about the ideal balance of dietary carbohydrates and fats. Research released this week contradicts anew some current recommendations of the American Diabetes Association. While the study is deemed "preliminary" by its authors, their findings suggest the need for a much larger clinical trial to settle the issue.

Weight loss and dietary modification are the cornerstones of therapy for patients with NIDDM, who have abnormalities in both glucose and lipid metabolism and are at increased risk of heart disease. The American Diabetes Association recommends a diet low in cholesterol and saturated fats to lower blood levels of low-density lipoproteins, a major risk factor for coronary heart disease. In part to make up for the loss of calories from such a diet, it also recommends a high intake of complex carbohydrates, including beans and grains. But new research suggests these patients might be better off replacing saturated fats not with carbohydrates but with monounsaturated fats such as olive oil.

Abhimanyu Garg and his colleagues at the University of Texas Southwestern Medical Center at Dallas compared various measures of diabetic health—including blood sugar levels, insulin requirements and levels of "good" and "bad" cholesterol subtypes—in 10 NIDDM patients whose diets were strictly controlled over a 10-week period in a metabolic-monitoring hospital ward. Compared with the low-fat, high-carbohydrate diet currently recommended, a diet low in carbohydrates and high in monounsaturated fat produced significantly better control of blood sugar levels and a superior balance of cholesterol subtypes, they report. The research appears in the Sept. 29 *New England Journal of Medicine.*

(*Note:* Reprinted with permission from *Science News*, the weekly newsmagazine of science, copyright 1989 by Science Service, Inc.)

What you always wanted to know but didn't know where to ask

(Resource list)

(Inclusion of materials in this publication is for information only and does not imply endorsement by the Diabetics Division of the NFB.)

Equipment

Inject Ease: Automatic insulin injection system "makes injections easy and comfortable." Suggested retail price: $25-$30. Contact Palco Labs, 1595 Soquel Drive, Santa Cruz, CA 95065; telephone toll-free: 1-800-346-4488 or (408) 476-3151.

Novolin Pen: This device looks like a fountain pen and can be carried in either shirt pocket or purse. When drawing insulin, an audible click will be heard for each two units drawn.

A multidose PenFill cartridge slips into the pen for several days' dosage of insulin. Three different cartridges of human insulin are available: the Novolin R PenFill contains regular human insulin injections (semi-synthetic); the Novolin N PenFill contains NPH human insulin isophane suspension injections (semi-synthetic); and the Novolin 70/30 PenFill contains a mixture of 70% NPH human insulin isophane suspension and 30% regular human insulin injections (semi-synthetic). All PenFill cartridges are sold in lots of five. The suggested retail price is $13. The suggested retail price for the Novolin Pen is $39.95. For information, contact: Novo-Nordisk Pharmaceuticals; telephone toll-free: 1-800-727-6500.

Plastic Insulin Gauge: This gauge is cut to fit over the insulin syringe plunger for accurate measurement. Mixing of insulins is possible. This is a simple device that works well for many blind diabetics. The cost is $1.50 per gauge. Contact: Boone's Kustom Kraft, 10517 San Gabriel Road N.E., Albuquerque, NM 87111; telephone: (505) 275-7645.

Table top sweetener

Equal: A recipe books which contains over 60 recipes is offered free in braille, large print, and on cassette. These recipes use the table top sweetener Equal, and include appetizers, beverages, entrees, salads, and desserts. Contact: NutraSweet Consumer Affairs, The NutraSweet Company, Box 830, Deerfield, IL 60015; telephone toll-free: 1-800-323-5316.

Moisture Cream

Anastasia Marie Revitalizing Moisture Cream: Satisfaction guaranteed if you purchase this new skin cream. The manufacturer says that the cream is "physician recommended for maintaining the optimum health and beauty of your skin" and it "renourishes and remoisturizes to improve skin texture and reduce the appearance of fine lines." The cost is $18.00.

The company carries other body lotions, such as Dia-Pedic Foot Treatment Program, Therapeutic Foot Treatment Oil, Invigorating Foot Cream, Aloe Rich Body Cream, Moisturizing Shaving Gel, and Moisturizing Bath Oil. Contact: Anastasia Maria, Inc.; telephone toll-free: 1-800-542-7546.

Literature

Diabetic Traveler: This is a quarterly magazine that provides information about travel, both domestic and outside the United States, for diabetics. This newsletter contains tips that will almost certainly be helpful to diabetics who plan to travel.

The yearly subscription cost is $15.00. Contact: *Diabetic Traveler*, P.O. Box 8223, Stamford, CT 06905; telephone: (203) 327-5832.

All New Cookbook for Diabetics and Their Families: This book contains more than 180 recipes including beverages, salads, meat entrees, vegetables, pastas, breads, soups, cheese, and desserts. This book says, "All recipes include exchange values plus calorie, cholesterol, carbohydrate, protein, fat, fiber, and sodium counts."

This book costs $12.95, and is published by Oxmoor House, Inc.

Diabetes 101: Candy Apples, Log Cabins & You, by Richard O. Dolinar, M.D. and Betty Page Brackenridge, M.S., R.D., C.D.E.: This new 117 page book is designed with the newly diagnosed diabetic in mind. The book uses a variety of metaphors such as "candied apples" or "log cabins" to explain what diabetes is and how to control it. A press release says, "The authors hope to bring newly diagnosed patients to a high level of understanding quickly, without resorting to complex medical explanations and terms."

This book costs $9.95, which includes a $2.00 handling fee. Contact: Diabetes 101, c/o Diabetes Center, Inc., P.O. Box 739, Wayzata, MN 55391.

Ann Terry is a registered dietitian. She works at the State Hospital in Fulton, Missouri and at the Veteran's Administration Hospital of Columbia, Missouri. She graciously calculates the diabetic exchanges and food values for our recipes.

Send your great ideas to the editor. He is the official taste tester and needs recipes to test his taster.

Chicken Pot Pie
Submitted by Gertrude Bryant
From Columbia, Mo.

Note: Gertrude is the mother of our editor and has had considerable experience cooking wonderful meals.

1 (one) medium chicken (approximately 2 lbs.)
1-1/4 cup Chicken Broth
1 can (10 3/4 oz.) cream of chicken soup
1 1 lb. can Vegeall or mixed frozen or drained vegetables
1 cup Bisquick
1 cup skim milk
1 stick light margarine, melted

Boil chicken until tender, then deskin and bone. Layer chicken broth, vegetables, and soup over chicken in casserole dish. In mixing bowl place bisquick, butter, milk; mix until smooth. Pour over chicken mixture in casserole. Bake at 350 degrees for 45 minutes or until crust browns and mixture thickens.

Do not cover casserole. Be creative with vegetables. Use same amounts of favorite fresh vegetables if desired.

Yield: 8 servings; Calories: 350; Exchanges: 2 meats, 2 breads, 1 fat.

Note: *The following recipes are from Mary Monell, who is Cook I at the Rehabilitation Center for the Blind in Topeka, Kansas.*

Diabetic Carrot Cake
Submitted by Mary Monell
From Topeka, Kansas

1/2 cup raisins
1/2 cup margarine
1 egg
1 cup oatmeal
1 tsp. soda
1 cup flour
3/4 cup sugar twin
1 tsp. vanilla
1/4 tsp. salt
1/2 tsp. cinnamon
1 can carrots (no. 16 can) sliced and juiced

Mix together. Pour into 9"x 9" oiled pan and bake at 350 degrees for 30 minutes.

Yield: 9 servings; Calories: 250; Exchanges: 2 breads and 2 fats.

Diabetic Punch
Submitted by Mary Monell
From Topeka, Kansas

3 pkg. Kool-Aid with Nutrasweet (no water)
1 46-oz. can pineapple juice plus 3 cans water
1 12-oz. frozen orange juice (no water)
1 12-oz. frozen lemon juice (no water)
Add sugar-free 7up (2 liter bottle)
Add ice.

Yield: 2 gallons; Serving size: 1 cup or 8 oz.; Calories: 50; Exchanges: 1 fruit.

NEW! **DIABETES EDUCATION VIDEO** NEW!

HEALTHY MEAL PLANNING - AWAY FROM HOME is a 16-minute video discussing "plan-ahead strategies" for formal and informal eating away from home. Selecting from restaurant menus, brown bag and travel tips are depicted by many visual examples. Three copy-ready handouts: a restaurant guide, brown bag suggestions and travel considerations accompany the video. Available in VHS or Beta. Send $49.95 to: Claire Hammer, RD, 524 Sherman Drive, Marshall, MI 49068. 30-day money back guarantee.

Tidbits and humor

National Convention

The annual convention of the National Federation of the Blind will be held this year in Dallas, Texas and attended by approximately 2,500 blind citizens. This will be a commemorative convention, because we were organized in 1940, and this year, 1990, is our 50th year of serving blind people.

There will be fellowship and learning as Information on all aspects of blindness will be covered. There will be an exhibit hall with hundreds of appliances on display and literature that may interest blind persons. Also, there will be tours offered which are always fun.

The convention will be at the Dallas-Fort Worth Hyatt Regency Hotel at the Dallas-Fort Worth Airport from Saturday June 30th to Friday July 6th. Rates are as follows: singles, $27.00; doubles and twins, $30.00; triples, $33.00; and quads, $36.00, plus a tax of at least 12%. For reservations, call toll free: 1-800-233-1234, or locally at (214) 453-1234.

When making reservations be sure to mention that you will be attending the National Federation of the Blind convention. If you have trouble with the hotel acknowledging our NFB special room rates, call the National Center for the Blind in Baltimore; phone: (301) 659-9314.

Dialysis

During this year's National Convention in Dallas, Texas, dialysis will be available.

Individuals requiring dialysis must have a transient-patient packet and a physician's statement filled out prior to treatment. Patients should have their dialysis units contact the desired location in Dallas for instruction on what must be done. There is a mandatory prepayment of 20 percent (approximately $25-$27) which must be paid before each dialysis treatment. This is the amount not covered by Medicare.

Following are two dialysis locations which are close to the Dallas-Fort Worth Airport Hyatt Regency:

1. Irving Dialysis Center, c/o Irving Community Hospital, 2845 W. Airport Frwy., Suite 120, Irving, TX 75062; phone: (214) 258-0880. For scheduling, contact: Dwight Stevenson, Director of Nursing. This dialysis location is open 6 days a week (Monday-Saturday). This unit is about 10 minutes from the hotel, right off the south entrance of the airport.

2. Dialysis Center HEB, 2700 Tibbets Drive, Suite 203, Bedford, TX 76021; phone: (817) 354-8811. For scheduling, contact: Louise, Head Nurse. This dialysis location is open 3 days a week (Monday, Wednesday, and Friday). This unit is about 15 minutes from the hotel, right off the south entrance of the airport.

Please schedule your dialysis treatments early, as space may be limited. If your dialysis unit cannot confirm a space for you, contact Ed Bryant for assistance at: 811 Cherry St., Suite 306, Columbia, MO 65201; phone: (314) 875-8911.

Hear Ye Hear Ye — A Raffle

The Diabetics Division of the National Federation of the Blind (NFB) reaches out and provides support and information to many people. This valuable networking costs money, such as the production cost for ***Voice of the Diabetic,*** and we must generate funds to help cover these costs.

Our Diabetics Division has elected to hold a raffle which will be coordinated by our capable treasurer, Bill Parker. The grand prize will be $200.00 and the winner's name will be drawn at this year's annual convention of the National Federation of the Blind on Thursday, July 5, 1990, in Dallas, Texas. In addition to the grand prize, the person who sold the winning ticket will receive $100.00.

The cost of each raffle ticket is one dollar, or a book of six may be purchased for five dollars. Tickets may be obtained from state representatives of our Diabetics Division or by contacting raffle ticket chairman, Bill Parker, 857 Ingleside Rd., Norfolk, VA 23502; phone (804) 623-1638 in the evenings. Anyone interested in selling tickets should also contact Bill Parker.

Bill Parker serves as Treasurer for the Diabetics Division of the National Federation of the Blind. He is an active Federationist who works hard to improve the lives of the blind.

Please make all tax deductible checks payable to the National Federation of the Blind. Money and sold raffle ticket stubs must be mailed to Bill Parker no later than June 15, 1990. Or, they can be personally delivered to Bill at this year's convention in Dallas, Texas. This raffle is open to everyone and raffle participants need not be present at the drawing to win.

Elections Coming Up

At this year's National Convention in Dallas, Texas, elections will be held to fill divisional board positions. These are one-year terms that will run from July 1, 1990 to June 30,

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Tidbits and humor

(Continued from page 15)

1991. Positions to be filled are: President, First Vice-President, Second Vice-President, Secretary, and Treasurer. If you are interested in a board position, or know someone who you think would do a good job, then contact our Diabetics Division president, Karen Mayry. Yes, hard work and dedication are prerequisites of each board position. Anything worthwhile is usually challenging and requires hard work. Leadership should be a positive force, and one should lead by good example.

From Argentina
by Ed Bryant

The *Voice of the Diabetic* is mailed to several foreign countries as diabetes causes blindness worldwide.

Cristina Cequiel from Buenos Aires, Argentina is a member of our NFB Diabetics Division, and always accentuates the positive about everything she does. Cristina had a pancreas and kidney transplant more than six years ago, which to date are working great. She is currently working on an article for the *Voice* which should be informative as well as inspiring.

Last year, Cristina had part of her foot amputated, and as our Diabetics Get Well Committee Chairman, I requested that people all over the country send her get well and/or appropriate greetings.

Cristina has asked that I send thanks to her many friends in the United States. A letter from her said in part: "Please tell all my American friends 'Thank you.' It's fine to know that at such long distance I have many friends that I hope to meet some day, if God lets me."

Cristina's friends in our country wish her health and happiness.

Christina Cequiel, from Argentina, is a member of the Diabetics Division of the NFB.

Think About It

Thinking leads men to knowledge. One may see and hear and read and learn as much as he pleases; he never knows any of it except that which he has thought over, that which by thinking he has made the property of his mind. Is it then saying too much if I say that man, by thinking only, becomes truly great?

— Johann Heinrich Pestalozzi

The following two bits of humor were submitted by Susan Manchester who serves as Vice President of our NFB Diabetics Division.

Q. How do you capture a unique bird?

A. You neak up on him.

Q. How do you capture a tame bird?

A. Tame way.

Plan Ahead and Be Prepared

At this year's Annual Convention of the National Federation of the Blind there will be many in attendance who are insulin dependent diabetics. Each of us should have foresight and bring extra insulin and syringes so as to avoid taking time out to go in search of a pharmacy. If the state of Texas requires a doctor's prescription, the added expense of a physician's visit would be necessary.

We insulin dependent diabetics should always be prepared in case of an insulin reaction. At a national convention the hotels are jammed with people and the restaurants are usually packed.

At every convention there are a few diabetics who undergo hypoglycemic attacks which, of course, can be avoided. THINK AHEAD! Always carry something sweet such as candy or glucose tablets that can be used for insulin reactions. We should be sure to have, in our rooms, snack foods that will help control our diabetic food needs.

We diabetics can travel anywhere and do almost anything we want. One thing we cannot do is to go without food.

Our bloodstreams should have a balance of insulin and glucose. If there is not enough glucose (food) then we have an "insulin reaction."

"Plan ahead and be prepared."

Oops!

In the last issue of the *Voice of the Diabetic,* two telephone numbers were incorrect. The correct listings are as follows.

Bill Parker, treasurer of our Diabetics Division; phone: (804) 623-1638.

Cheryl McCaslin, resource librarian of our Diabetics Division; phone: (214) 528-8107.

Display Tables

This year's annual convention of the NFB will take place in Dallas, Texas, and at this momentous event our Diabetics Division has reserved space in the exhibit hall.

There will be hundreds of display tables with products and information that may be of interest to blind persons.

Our Diabetics Division will display literature and equipment that will be of interest to blind diabetics or to any person with diabetes.

CAN YOU HELP? It takes many people to work our display tables, and if you can help for two hours, four hours, or more, please contact our display table chairman: Bill Parker, 857 Ingleside Road, Norfolk, VA 23502; phone: (804) 623-1638.

Braille Calendars

The American Brotherhood for the Blind is offering, free-of-charge, an attractive 1990 calendar in braille. Just write to the American Brotherhood for the Blind, 1800 Johnson St., Baltimore, MD 21230.

ADVERTISERS

Effective advertising doesn't scream at its audience. It persuades. It sells. The key to cost-effective advertising is making your voice heard where an audience is already listening. *Voice of the Diabetic* offers such an outlet. Make *your* voice heard. For advertising information contact:

Voice of the Diabetic
Ed Bryant, Editor
811 Cherry Street, Suite 306
Columbia, MO 65201
(314) 875-8911

Subscription/Donation/Membership Form

Voice of the Diabetic is a quarterly magazine for anyone interested in diabetes, especially diabetics who are blind or losing vision. The $5.00 annual membership fee of the Diabetics Division of the National Federation of the Blind (NFB) entitles you to a year's subscription to **Voice of the Diabetic**. However, production cost per annual subscription of the **Voice** is about $15.00, and for this reason we must charge all non-members, health professionals and institutions $15.00 for an annual subscription. Of course, all donations are accepted and very much appreciated.

You may receive the *Voice* as a member or non-member. ***Please check one:***

☐ I would like to become a member of the Diabetics Division of the NFB and receive a free subscription (one year) to *Voice of the Diabetic:* ($5.00)

☐ I would like to subscribe to *Voice of the Diabetic* as a non-member, health professional, or institution. ($15.00/one year; $28.00/two years; $40.00/three years)

The *Voice* is available in print or on half-speed (15/16 ips) cassette tape; cassettes are provided at no extra cost. ***Please check one box.*** I would like to receive *Voice of the Diabetic:*

☐ in print ☐ on cassette tape ☐ both in print and on cassette tape

Optionally, check this box:

☐ I would like to make (or add) a tax-deductible contribution of $_____ to the Diabetics Division of the NFB.

Please print clearly

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number (_____) _____

Send this form or a facsimile along with your check to our editor:

Ed Bryant, 811 Cherry St., Suite 306, Columbia, MO 65201

Please make all checks payable to the **NATIONAL FEDERATION OF THE BLIND.**